Child and Adolescent Mental Health Division

Support for Emotional and Behavioral Development

Referral Process and Forms

Table of Contents

STATE OF HAWAII
DEPARTMENT OF HEALTH
CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
3627 KILAUEA AVE RM 101 HONOLULU HAWAII 96816
PHONE: 733-8370 FAX: 733-8375

FREQUENTLY ASKED QUESTIONS
FOR SERIOUS EMOTIONAL and BEHAVIORAL DISTURBANCE (SEBD)

1. **What is SEBD?**
   SEBD stands for Serious Emotional and Behavioral Disturbance.

   Under the Felix Consent Decree, the DOH CAMHD Family Guidance Centers only served those students identified by the school as having an educational impairment because of a mental health issue. These students were identified via the IDEA and 504 processes.

   Now that we are in substantial compliance with the Consent Decree, we are able to broaden our eligibility to include children and adolescents who may have a significant mental health issue, but do not necessarily meet the IDEA or 504 eligibility criteria. Through an agreement with Med-QUEST, CAMHD is able to serve those youth under the category of SEBD.

2. **What is the SEBD eligibility criteria?**
   Children and adolescents with serious emotional and behavioral disturbances are defined as those individuals who have a (current) CAFAS score of 80 or higher and have an acceptable primary DSM-IV Axis I diagnosis at any time during the past year. In order to be served by CAMHD under the SEBD category, an individual must be QUEST or Fee-For-Service insured. Please see the attached handouts for more information about the eligibility criteria.

3. **Can a youth be both Felix and SEBD eligible?**
   Yes. SEBD and Felix are not mutually exclusive categories. The Family Guidance Center serves children and adolescents who are classified as SEBD, Felix, or both.

   The Family Guidance Centers are currently screening the Felix youth we already serve to determine which of them may also be eligible under SEBD. In addition, if we receive a client through the SEBD process, and it looks like they may need to be screened by the school for Felix eligibility, we will advise the guardian to go through the 01 process at their home school.

4. **What is the benefit of referring a youth to be served under SEBD?**
   If a youth has been found eligible for CAMHD services under SEBD, they can receive our services regardless of their IDEA or 504 status as long as they still meet the SEBD criteria. In addition, the mental health services needed under SEBD do not need to be IEP or MP driven, if they are not directly related to the educational progress of the youth.

   Therefore, if a youth classified as both SEBD and IDEA or 504 and the youth needs a change in services, the service change can be made under the SEBD classification and the IEP or MP only needs to be changed if the services affect the educational placement of the youth.

5. **Are there any disadvantages to classifying a youth as SEBD?**
   Some parents may be concerned about the stigma attached to the SEBD label.

6. **What services does a youth receive once they are determined to be SEBD?**
   If a youth is found to be SEBD eligible, they will be served by the Family Guidance Center staff and can receive any of the intensive services in the CAMHD service array that is appropriate to the needs of that individual. If anyone on the youth's treatment team disagrees with the services being offered, they can then file an appeal of the decision.

7. **If an SEBD youth requires outpatient services, who provides those?**
   If a youth has an IEP or an MP, and outpatient services have been identified as an educational need by the team and are reflected in those educational plans, then the youth will receive those services through DOE School-Based Behavioral Health (SBBH) services.

   If a youth requires an outpatient service that is not in an IEP or MP, the Family Guidance Center will procure the needed outpatient service through the QUEST or Fee-For-Service insurance service array or may provide services available through licensed clinical FGC staff (e.g. assessment, medication management) or through FLEX funding.

8. **What is the referral process?**
   Please see the attached referral checklist and paperwork. A referral source should submit this paperwork to the Family Guidance Center, within the youth's home district.

   Once a determination has been made about a youth's eligibility, a notification will be sent to the guardian and the referral source to indicate whether or not the youth was found eligible. CAMHD has 30 days from the receipt of a **complete referral packet** to make this determination.

9. **What if I don't have all the information needed to make a referral?**
   To the extent possible, we do ask that a referral packet be complete. There are times, however, when a packet comes in without a CAFAS or current mental health evaluation. In those instances, the Family Guidance Center can assist the referral source in obtaining those elements of the referral packet. Patient needs to be registered in our system before we can provide or procure services.

10. **Who can make a referral to request that a youth be screened for SEBD eligibility?**
    Anyone can make a referral. If you work with a youth that appears to meet the SEBD criteria, you can refer that youth to the FGC to be screened for eligibility. In order for CAMHD to screen or to complete an assessment for the SEBD determination, CAMHD will need a consent form from the parent or legal guardian.

STATE OF HAWAII
DEPARTMENT OF HEALTH
CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

S SERIOUS

E EMOTIONAL AND

B BEHAVIORAL

D DISTURBANCE

What is SEBD?

SEBD is Serious Emotional and Behavioral Disturbance formerly known as SED or Serious Emotional Disturbance.

Who can be referred?

Age 3 through 18 (through 20 if there is still an active educational plan)

AND

QUEST eligible or Fee-For-Service eligible

What are the eligibility requirements?

CAFAS 80 or above

AND

Eligible DSM-IV diagnosis

What are the benefits?

A child/youth determined to be SEBD is entitled to receive appropriate CAMHD intensive mental health services.

How is a child/youth referred for SEBD services?

1. The referral source makes an informal evaluation that the child/youth may be eligible for SEBD based on the child/youth's clinical information.

2. The referral source is responsible for completing the SEBD referral packet, which includes the:

    a. SEBD Referral Form;

    b. Checklist of Required Information for SEBD; and

    c. All available supporting documents.

    It is recommended that the referral source obtain the behavioral assessments from the QUEST Health Plan or Fee-For-Service provider. Periodic screening of behavioral health conditions is included in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) scope of services. EPSDT is Medicaid's comprehensive and preventive child health program for individuals under the age of 21.

    It is also recommended that the referral source submit all the documents/ information on the checklist to expedite the process.

    Referral for an inpatient child/youth should be submitted at least two working days before the anticipated discharge.

3. The referral source signs the SEBD Referral Form and mails or faxes the SEBD referral packet to the DOH CAMHD QUEST Plan Coordinator or to the appropriate DOH CAMHD Family Guidance Center (FGC).

    If the referral source is the QUEST Health Plan, the Health Plan Medical Director must review the referral packet and sign the SEBD Referral Form.

4. If the packet is incomplete, the QUEST Plan Coordinator forwards the SEBD referral packet to the appropriate Family Guidance Center for completion. The QUEST Plan Coordinator notifies the referral

source which Family Guidance Center the SEBD referral packet has been forwarded to. A DOH CAMHD FGC Care Coordinator is assigned to the child/youth. The Care Coordinator:

a. Links up with the referral source;

b. Obtains consent from the parent/guardian to conduct behavioral assessments on the child/youth for the completion of the SEBD referral packet;

c. Registers the child/youth in the Family Guidance Center;

d. Obtains any missing information listed in the Checklist of Required Information necessary for SEBD referral;

e. Connects with the Primary Care Physician; and

f. Mails or faxes the completed referral packet to the QUEST Plan Coordinator.

If the QUEST Plan Coordinator verifies that the SEBD referral packet is complete, the packet is forwarded to the DOH CAMHD SEBD Review Panel for the child/youth's SEBD eligibility determination.

5. The SEBD Review Panel makes a determination based on the information submitted.

   The review process takes between seven working days to not more than 30 working days from the receipt date of the <u>complete</u> SEBD referral packet.

6. The QUEST Plan Coordinator notifies the following of the SEBD Review Panel's decision:

   a. Family Guidance Center;

   b. QUEST Health Plan; and

   c. Med-QUEST Division.

7. If the SEBD Review Panel determines that the child/youth is eligible for SEBD, the child/youth is assigned to the Family Guidance Center serving the child/youth's geographic area of residence. A Care Coordinator is assigned to the child/youth. The Care Coordinator:

    a. Links up with and notifies the referral source of the SEBD Review Panel's decision;

    b. Notifies the Primary Care Physician of the SEBD Review Panel's decision;

    c. Notifies the parent/guardian of the SEBD Review Panel's decision;

    d. Obtains consent from the parent/guardian for the child/youth's SEBD treatment and periodic reviews;

    e. Registers the child/youth in the Family Guidance Center; and

    f. Arranges all mental health services for the child/youth.

8. If the referral source does not agree with the SEBD Review Panel's decision, the referral source may submit a *reconsideration*.

    A new SEBD referral packet, along with the original SEBD Referral Form, is submitted to the QUEST Plan Coordinator or Family Guidance Center within 15 working days from the date of notification of the SEBD Review Panel's decision on the initial SEBD referral. A decision on the reconsideration is rendered between seven working days and not more than 30 working days after the receipt of the resubmitted <u>complete</u> SEBD referral packet.

9. If the referral source does not agree with the SEBD Review Panel's decision on the reconsideration, the referral source may file a *grievance*.

    The referral source contacts the CAMHD Grievance Office at 1-800-294-5282.

10. An SEBD client undergoes a *periodic review* to check the eligibility for continued SEBD services. The frequency of the periodic review is specified by the SEBD Review Panel.

11. In order for an SEBD client to be discharged from the Family Guidance Center, an SEBD periodic review must first be conducted, thoroughly reviewed, and approved by the SEBD Review Panel. If the client no longer meets the criteria, provisional status may be continued to permit the transition of the client to alternative services.

    The discharge is not done abruptly. Care coordination and transitional planning is implemented during the transitional period. Provisional SEBD eligibility status is maintained throughout the duration of the transitional planning.

12. The QUEST Plan Coordinator notifies the following of the SEBD Review Panel's decision:

    a. Family Guidance Center;

    b. QUEST Health Plan; and

    c. Med-QUEST Division.

13. The Care Coordinator notifies the following of the SEBD Review Panel's decision:

    a. Referral source;

    b. Primary Care Physician; and

    c. Parent/guardian.

Who do you contact if you have questions?

- For questions about the SEBD eligibility criteria (i.e. eligible DSM-IV diagnoses, CAFAS), array of CAMHD intensive mental health services, SEBD Review Panel decision, or other clinical questions, and for a listing of CAFAS-trained providers, contact the DOH CAMHD Clinical Services Office and/or DOH CAMHD Medical Director at 733-9349.

- To request copies of the SEBD referral process and forms, contact the DOH CAMHD QUEST Plan Coordinator at 733-8370.

    - Fax: 733-8375 or 733-8383

    - Mailing Address:

State of Hawaii
Department of Health
Child and Adolescent Mental Health Division
ATTN: QUEST PLAN COORDINATOR
3627 Kilauea Ave, Rm 101
Honolulu, HI 96816

- For assistance in completing an SEBD Referral Packet or for questions about an SEBD-determined child/youth, contact the appropriate DOH CAMHD Family Guidance Center.

Attachments

1. SEBD Criteria
2. Checklist of Required Information for SEBD
3. DOH CAMHD Consent to Evaluation/Treatment
4. DOH CAMHD Authorization to Release/Obtain Confidential Information
5. SEBD Referral Form
6. DOH CAMHD Family Guidance Center Contact Information

CRITERIA FOR DETERMINATION OF ELIGIBILITY FOR CAMHD BEHAVIORAL HEALTH PLAN FOR SEBD CHILDREN AND YOUTH

I. CRITERIA

Children and youth with serious emotional disturbance are individuals who have a CAFAS score of 80 or above and currently, or at any time during the past year, have had a primary DSM-IV diagnosis.

II. EXCLUDED DIAGNOSES

If the diagnoses listed below are the only DSM IV diagnoses, the child is ineligible for SEBD services. These diagnoses, however, may and often do co-exist with other DSM IV diagnoses, which make the youth eligible for SEBD services:

Mental Retardation

317	Mild Mental Retardation
318.0	Moderate Mental Retardation
318.1	Severe Mental Retardation
318.2	Profound Mental Retardation
319	Mental Retardation, Severity Unspecified

Learning Disorders

315.0	Reading Disorder
315.1	Mathematics Disorder
315.2	Disorder of Written Expression
315.9	Learning Disorder NOS

Motor Skills Disorder

315.4	Developmental Coordination Disorder

Communication Disorders

315.31	Expressive Language Disorder
315.32	Mixed Receptive-Expressive Language Disorder
315.39	Phonological Disorder
307.0	Stuttering
307.9	Communication Disorder NOS

Pervasive Developmental Disorders

299.00	Autistic Disorder
299.80	Rett's Disorder
299.10	Childhood Disintegrative Disorder

299.80 Asperger's Disorder
299.80 Pervasive Developmental Disorder NOS

Substance Abuse Disorders

Mental Disorders Due to a General Medical Condition

III. PROVISIONALLY QUALIFIED

Children and youth provisionally qualified as SEBD are defined as those:

- Who have a substance abuse condition and are suspected to suffer from a qualifying condition due to their symptoms and functional limitations. These children and youth have ongoing and recent substance abuse which prevents the clinician from making a definitive qualifying diagnosis.
- Cases in which the impairment is profound and short term.
- Whose degrees of impairment falls mainly within the emotional/self-harm domains who show strong evidence of serious disturbance.

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CHECKLIST OF REQUIRED INFORMATION

FOR SERIOUS EMOTIONAL and BEHAVIORAL DISTURBANCE (SEBD)

INSTRUCTION: See SEBD Referral Process Steps 5 & 6. All documents are required for submission, unless not applicable to client. Check box or put N/A if not applicable. Fax with SEBD Referral Form or SEBD Periodic Review Form.

☐	1. SEBD Referral Form or SEBD Periodic Review Form
	Most recent (within six months):
☐	2. Parent/guardian consent
	3. Assessments (psychological and psychiatric assessments to include behavioral observation and presentation, diagnostic impression, and substance abuse information):
☐	a. Child and Adolescent Functional Assessment Scale (CAFAS)
☐	b. Functional Behavioral Assessment (FBA)
☐	c. Mental Health Assessment (MHA)
☐	d. Other _____
	4. Service/ treatment plans:
☐	a. Behavioral Support Plan (BSP)
☐	b. Mental Health Treatment Plan (MHTP)
☐	c. Coordinated Service Plan (CSP)
☐	d. Out-of-home residential or substance abuse treatment plan
☐	e. Other _____
	5. History:
☐	a. Personal
☐	b. Family
☐	c. Social
☐	d. Drug use
☐	e. Mental health
☐	f. Education
☐	g. Psychiatric care
☐	h. Physical examination
☐	i. Other _____
	6. Summary:
☐	a. Hospital admission/discharge
☐	b. Day hospitalization admission/discharge
☐	c. Outpatient admission/discharge
☐	d. Out-of-home residential or substance abuse program
☐	e. Other _____
☐	7. Psychological test or psycho-educational test results
☐	8. List of prescribed psychotropic medications
☐	9. Other _____

Child and Adolescent Mental Health Division

Consent to Evaluation/Treatment

Name of Consumer (Last Name, First Name and Middle Name)	Birthdate - MM/DD/YY

Name and Address of Person to Provide Treatment		
☐ Consent to Evaluation Only	☐ Consent to Initial Treatment	☐ Consent to Develop a Comprehensive Treatment Plan

Conditions to be treated, including diagnosis or probable diagnosis:
Purpose(s) of proposed treatment or recommended procedures:
Specific treatment(s) proposed:
Summary of recognized benefits and risks of the proposed treatment and alternatives, including no treatment, and anticipated results of treatment which are verbally explained.

For the person(s) providing consent:

- ☐ (Initial Consent Only) The booklet on my rights was given and explained to my satisfaction, including the name of my Rights Advisor.
- ☐ I hereby consent to the evaluation/treatment proposed above.
- ☐ I was able to ask questions and receive answers about this proposed treatment.
- ☐ I understand that I may obtain a second opinion.
- ☐ I understand that I may withdraw my consent prior to or during treatment.
- ☐ I understand that the anticipated results of treatment is not guaranteed.
- ☐ I understand that certain records about me/my child and my/my child's treatment shall be kept in written and computerized form.

Printed Name of person(s) providing consent:	Relationship to consumer

Signature(s) of person(s) providing consent:	Date:

Name (Printed and Signature) of staff person providing information and obtaining consent		Date:
	Title of Person:	

This consent expires on this date:

This consent is withdrawn effective this date: _____

Signature of parent/guardian:

Child and Adolescent Mental Health Division

Instructions: Consent to Evaluation / Treatment Form

1. Name and Address of Treatment Provider:

   Type or stamp the name and address of your Family Guidance Center (FGC).

2. Type of Consent

   Check any or all as applicable.

3. Conditions, Purpose, and Specified Treatment:

   Must be **specific** to individual consumer's problems. **Do Not Use pre-typed "boiler-plate" statements.**

4. Summary of Benefits and Risks:

   Briefly describe the best and the worst that could result from your proposed treatment; from no treatment, and whether there are any alternatives.

5. Consumer Rights Handbook:

   Generally review the contents of the handbook with the parent or guardian and encourage them to ask questions.

6. Obtain the required printed names and signatures.

7. Indicate the date the consent expires.

8. If at any time the consent is withdrawn, indicate the effective date and attempt to obtain the parent's and guardian's signature. If unable to obtain signature, indicate "Signature not available" on the signature line. Document in the chart the reason for the withdrawal.

State of Hawaii Department of Health
Child and Adolescent Mental Health Division

Authorization to Release/Obtain Confidential Information

Name of Client (Last Name, First Name and Middle Name)	Client's Birthdate - MM/DD/YY

I, (parent/guardian)_____, hereby agree that the Child and Adolescent Mental Health Division may ☐ release ☐ obtain information about my child specified below ☐ to ☐ from the following individual or organization whose legal authority has been verified by CAMHD.

Name: First Name Middle Name Last Name

Organization

Street Address:

City: State: Zip:

This information includes:

1) substance use information: ☐ Yes ☐ Not applicable _____ parent/guardian's initials

2) HIV/AIDS information ☐ Yes ☐ Not applicable _____ parent/guardian's initials

If either of the above information is to be released or obtained, specific benefits, risks and alternatives need to be addressed.

Purpose for Information:

Specific information requested:

Benefits, risks and alternatives to releasing/obtaining information:

Date, event/condition upon which this consent expires:

The form in which this information will be shared: ☐ written ☐ verbal (check appropriate box)

For the person(s) providing consent:

☐ This consent has been made freely, voluntarily and without coercion.
☐ I was able to ask questions and receive answers about this release.
☐ I hereby authorize releasing/obtaining the information as specified above and further understand that:

- Those who receive this information cannot disclose it to others without my further consent, unless permitted by Federal or State law.
- I may withdraw this consent any time before the information is released.

Printed Name of person(s) providing consent:	Relationship to consumer

Signature(s) of person(s) providing consent:	Date:

Name (Printed and Signature) of staff person providing information and obtaining consent

Printed:	Title of Person:	Date
Signature		

☐ Original to Third Party ☐ Copy for File ☐ Copy to Person Providing Consent

STATE OF HAWAII
DEPARTMENT OF HEALTH
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3627 KILAUEA AVE RM 101 HONOLULU HAWAII 96816

REFERRAL FORM
FOR SUPPORT FOR EMOTIONAL and BEHAVIORAL DEVELOPMENT (SEBD)

INSTRUCTION: Complete Part 1 and fax it, with a cover page, to a CAMHD Family Guidance Center.
For questions, call 1-800-294-5282.

PART 1. (TO BE COMPLETED BY THE REFERRAL SOURCE)

CLIENT INFORMATION

Last	First	Middle	Gender
			Select One

Date of Birth:	Social Security Number
	- -

QUEST/Medicaid FFS ID:	Med-QUEST Eligibility Date	Health Plan Name

Parent/Legal Guardian: Enter Complete Name LAST, First, Middle	Phone No:
	( )

Mailing Address: P.O. Box of Street Address, City, State, Zip Code

I hereby consent to the evaluation of my child for the purpose of determining SEBD eligibility and agree that CAMHD may obtain information about my child in the understanding that it cannot be disclosed to others without my further approval, unless permitted by Federal or State law. I also understand that this consent expires in one year.

Parent/Legal Guardian Signature: _____ Date _____

REFERRAL SOURCE INFORMATION

Referral Submission Date:	Referral Type: ☐ Initial ☐ Reconsideration
Referring Agency/Organization	Address
Referring Person's Name (LAST, First, Middle)	Phone ( ) Fax ( )

I hereby certify that I have reviewed this referral and concur with the recommendation for the above client's SEBD status.

Referring Person's Signature: _____ Date: _____

MORE CLIENT INFORMATION

DSM-IV DX CODE	Axis I	Axis II	Axis III	Axis IV	Axis V
Primary					
Secondary					
Diagnosis Date:		Diagnosed By:			

CAFAS (CHILD AND ADOLESCENT FUNCTIONAL ASSESSMENT SCALE)	SUPPORTING DOCUMENTS (List & attach new assessments and plans to support diagnoses. If insufficient space, continue on separate sheet.)
School/Work Role Performance	Assessments
Home Role Performance	
Community Role Performance	
Behavior Toward Others	Treatment / Service Plans
Moods/Emotions	
Self-Harmful Behavior	
Substance Abuse	Others
Thinking	
8-SCALE TOTAL SCORE	

Client Name: LAST, First Middle _____, _____

PSYCHOSOCIAL INTERVENTION STRATEGIES UTILIZED
(Check all that apply. If insufficient space or for other approaches, continue on separate sheet.)

Individual Therapy	Group Therapy	Family Therapy
☐ Individual Therapy	☐ Group Therapy	☐ Family Therapy
☐ Individual Interpersonal Therapy	☐ Group Psychoeducational Therapy	☐ Parent Psychoeducational Therapy
☐ Biofeedback Therapy		
☐ Cognitive Behavioral Therapy		
☐ Exposure Therapy		

HISTORY OF HOSPITALIZATION (Start with current hospitalization. If insufficient space, continue on separate sheet.)

Facility Name	Location	Admit Date	Discharge Date	Diagnoses

HISTORY OF MEDICATION TRIALS (Start with current medication. If insufficient space, continue on separate sheet.)

Medication Name	Strength	Freq	Start Date	End Date	Managing Physician	If Discontinued, Specify Reason

HISTORY OF OUTPATIENT TREATMENT (Start with current. If insufficient space, continue on separate sheet.)

Therapist/ Provider	Diagnoses	Start Date	End Date

PART 2. (TO BE COMPLETED BY THE FAMILY GUIDANCE CENTER)

FGC: change this to drop down menu	CR#:
Registration Date:	Educational Status & Date:
CAMHD/MQD BH Carveout Dates:	

I hereby certify that I have reviewed this referral and reviewed the recommendation for the above client's SEBD status and recommend SEBD: ☐ *Yes* ☐ *Provisional* ☐ *No.*

Clinical Director Signature: _____ Date: _____

PART 3. (TO BE COMPLETED BY THE SEBD REVIEW PANEL)

Current Review Date:	Next Review Date:
SEBD Determination: ☐ Yes ☐ Provisional ☐ No	SEBD Begin Date:
Comments: ☐ Criteria Met ☐ Criteria Not Met ☐ Other (see below)	

Medical Director Signature: _____ ALFRED M. ARENSDORF, MD

STATE OF HAWAII
DEPARTMENT OF HEALTH
CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
3627 KILAUEA AVE RM 101, HONOLULU HAWAII 96816

PERIODIC REVIEW / PRE-DISCHARGE FORM
FOR SUPPORT FOR EMOTIONAL and BEHAVIORAL DEVELOPMENT (SEBD)

INSTRUCTION: Complete Part 1 & 2 and fax it (808) 733-8383, with a cover page, to the CAMHD QUEST SEBD Plan Assistant. For questions, call (808) 733-8370.

PART 1. (TO BE COMPLETED BY THE CARE COORDINATOR)

CLIENT INFORMATION			
Last	First	Middle	Gender Select One
Date of Birth: dd/mm/yy - -		Social Security Number - -	
QUEST/Medicaid FFS ID:	Med-QUEST Eligibility Date	Health Plan Name	
Parent/Legal Guardian: Enter Complete Name LAST, FIRST, MIDDLE			Phone No: ( )
Mailing Address: P.O. Box of Street Address, City, State, Zip Code Hawaii .			

DSM-IV DX CODE	Axis I	Axis II	Axis III	Axis IV	Axis V
Primary					
Secondary					
Diagnosis Date:		Diagnosed By:			

CAFAS (CHILD AND ADOLESCENT FUNCTIONAL ASSESSMENT SCALE)	**SUPPORTING DOCUMENTS** (List & attach new assessments and plans to support diagnoses. If insufficient space, continue on separate sheet.)
School/Work Role Performance Home Role Performance Community Role Performance Behavior Toward Others Moods/Emotions Self-Harmful Behavior Substance Abuse Thinking 8-SCALE TOTAL SCORE	Assessments Treatment / Service Plans Others

FGC INFORMATION		
FGC: Select One FGC	CR#:	
Registration Date:	Discharge Date:	
Educational Status & Date:		Date:
CAMHD/MQD BH Carveout Dates:		

Client Name: _____

CURRENT STATUS (Services, frequency/ intensity, school, medication, etc.)
I hereby certify that I have reviewed this referral and reviewed the recommendation for the above client's SEBD status and recommend SEBD: ☐ *Yes* ☐ *Provisional* ☐ *No*
Care Coordinator Signature: _____ Date:

PART 2. (TO BE COMPLETED BY THE CLINICAL DIRECTOR)

JUSTIFICATION & RATIONALE

RECOMMENDATIONS
I hereby certify that I have reviewed this referral and reviewed the recommendation for the above client's SEBD status and recommend SEBD: ☐ *Yes* ☐ *Provisional* ☐ *No*
Clinical Director Signature: _____ Date:

PART 3. (TO BE COMPLETED BY THE MEDICAL DIRECTOR)

Current Review Date:		Next Review Date:	
SEBD Determination:	☐ Yes ☐ Provisional ☐ No	SEBD End Date:	
Comments:	☐ Criteria Met	☐ Criteria Not Met	☐ Other (see below)
Medical Director Signature: _____ Alfred M. Arensdorf, M.D.			